Supporting Skill Development of Adults with Intellectual Disabilities within a Day Service Environment.

Karyn Willoughby BSc MSc (Development Studies)
For Oakleigh Centre
773 Warrigal Rd, Oakleigh, Victoria 3166
03 9569 0603
karry-w@hotmail.com
http://www.oakleighcentre.org/
April 2014
‘History can do many things. Firstly, it can show us that the past is never the story of smooth, unproblematic progress. Advances in every field can be reversed, optimism replaced by pessimism; we can go backwards, just as easily as we can go forwards. History can also show us the impermanence of the present, which is perhaps another way of saying that the future is in our hands. It can provide both long and short term lessons and the history of intellectual disability is full of lessons both learned and unlearned’ (Charlie Fox 2008).
Introduction

In Victoria almost one in five people, 18.5% of the population have a disability and 6.1% have a moderate to severe intellectual disability (ABS 2013). The majority of people who experience a moderate to severe intellectual disability will not access formal post high school services; they may avail of 1:1 support or group placement within day services. The DHS define day services as:

“Day services is used... to describe the range of activities and requirements where a person elects to use their funding to purchase a place as part of a group service... it describes the provision of activities for a group of people whilst adopting a self-directed and tailored approach for the participants as individuals. The provider works with each person to meet their requirements to the greatest extent as possible” (DHS 2001: 3).

Day services provide a range of activities for their service users to participate in. These activities are designed to be interesting for the people who choose the activity, to be reflective of the interests of the wider community and to be fun. As day services are an alternative to formal education or employment, it is essential for their service users to continually practice and develop their current skills and such skills must be developed within activities.

The goal of this report is to provide staff with a guide that will provide teaching tools that can be used to continue and develop learning outcomes (skills) of adults with moderate to profound intellectual disabilities.

In order to complete its overall goal, this report will aim to

Section 1:

1) Describe the history of special education within Australia.
2) To highlight the importance of supporting people to achieve their full potential through developing their skills (law and morality).

Section 2:

3) To outline the most current teaching and learning frameworks enforced by the Department of Human Service Standards 2011.

4) To outline teaching tools that can be used by staff to promote skill development of participants through the models of strength based learning and active engagement.

The information used to complete this report has been gathered from websites, speeches, lecture slides and journal articles.
Section 1: The History of Special Education in Australia

Institutional care

The provision of education for children with disabilities in Australia begins in the 1700’s (18th century) and the 1800’s (19th century). During this time Britain began creating large asylums (institutions) for the insane, a category in which people with intellectual disabilities were included. These hospitals were huge buildings that intended to cure, rehabilitate and segregate the “idiots” and “imbeciles” of the community through training and education. Instead, these places became crowded, run down and the people inside were soon forgotten. Doctors recommended families to send their children to these hospitals and forget about their children as they cannot love or be loved. Most parents obliged under the belief that their child would receive appropriate training and education.

As Australia was under British rule, what happened in Britain consequently happened in Australia, and asylums were constructed. In Tasmania the New Norfolk Hospital was built in 1827. In Perth the Fremantle Lunatic Asylum was built in 1861 and Kew Lunatic asylum was constructed in Victoria in 1871. These hospitals were created to rehabilitate both people with mental health problems (“the insane”) and people with intellectual disabilities. In 1887 Kew Idiot Asylum was built and in 1929 its name was changed to Children’s Cottages Kew.

During the 1860’s some schools were set up for children who were deaf and blind. These schools were also separate to mainstream schools.

In France during the 1840’s the first recorded theory about the skill development of people with intellectual disabilities was being produced. Edouard Seguin, dubbed the ‘apostle of idiots’ by the Pope developed a theory that a psychological treatment for young adults could awaken their dormant talents. This theory spread to Britain and America and new institutions were built to separate people with intellectual disabilities from people with mental health illnesses.
According to Charles fox (2008) the Seguinian method was only used in Kew Hospital and in Perth at Claremont Hospital (replaced Fremantle Lunatic Asylum). At Kew Hospital during the 1880’s an educational programme was set up to educate young children with intellectual disabilities. At Claremont in the early 20th century a Montessori school was opened for a short period of time. In 1924 two special schools Dora Turner and Talire, were opened in Tasmania. Soon after these programmes were established ‘this optimism was soon turned to pessimism. Once again, overcrowding, lack of money and a sense that cure and education were too difficult, soon undermined optimism and, increasingly like the hospitals for the insane, these places also became gigantic warehouses where inmates lived their lives invisibly concealed from the public’ (Charles Fox 2008).

Between 1900 and 1945 an international pseudo-science called Eugenics flourished. The purpose of this thinking was to create a stronger, protected, white race. To do this it ‘proposed to strengthen the race by eliminating the capacity of the weak to reproduce’ (Charles Fox 2008), it focused first on those with intellectual disabilities. In Australia this thinking was practiced through forced segregation, in many states of the US they implemented forced sterilisation and the most extreme practice was in Nazi Germany, where people with intellectual disabilities were killed.

**Parental groups**

After WW2 change began. Eugenics was discredited and many parents who had children with intellectual disabilities began to demand a better future for their children. In 1948 the United Nations produced a Declaration of Human Rights to ensure the inhumane treatment of humans would never occur again. This declaration inspired parental thinking about the rights of their children with intellectual disabilities and towards a future other than that of institutionalised life. In 1951 parents of children with moderate intellectual disabilities set up the Western Australian Slow Learning Children’s Group (SLCG). In 1954 parents of children with severe to profound intellectual disabilities established the Mentally Incurable Children’s Association (MICA) as they felt SLCG was unable to offer their children the support that they needed. These groups began putting pressure on the government to provide medical, educational and training services for their children.
‘The SLCG... believed that with proper training, their children had the potential to work... both males and females ended up in the same place, working in the sheltered workshops set up by the SLCG itself’ (Charlie Fox 2010). The SLCG began to take off and membership grew. The children of the parents within the SLCG and MICA stayed at home and the SLCG established pre-schools and schools training centres and workshops for young adults. The SLCG set up a farm colony and Irabeena was established to assist parents with diagnosing and treating their children.

In 1952 the Mental Health Department bought two houses in Guildford, Victoria, where fifty people from Claremont Hospital were sent to receive education and training. These two houses were the first houses that paved the way for deinstitutionalisation in the future. In Perth MICA set up a home called Nulsen Haven. This home was set up for children with severe to profound intellectual disabilities.
Normalisation and Social Role Valorisation

It was not until the 1960s and 1970s that the disability sector as we know it today began to emerge. During the 1960’s Wolfensberger created two principles that laid the foundations of future service provision and public policy from the 1970’s. The first was the theory of Normalisation. This theory ‘promoted making available to all people with disabilities, patterns of life and conditions of everyday living which are as close as possible to regular circumstances and ways of life or society including housing, schooling, employment, exercise, recreation and freedom of choice (1972)’ (DSA 2013). Social Role Valorisation was the second theory and this was based upon the idea that if a person or group held valued social roles they were more likely to receive the good things in life (education, dignity, respect etc). Social Role Valorisation aimed to ‘enabling, establishing, enhancing, maintaining and defending valued social roles (Thomas and Wolfensberger 1999 cited in DSA 2013). A shift from a medical model of care to a developmental model of care based on social health and wellbeing was beginning to come to the fore and this would soon greatly affect the education of people with intellectual disabilities.
Mental Health and Intellectual Disability Separate

Influenced by the Mental Health Act of 1959, in 1964 people who had mental illnesses were formally separated from those who had intellectual disabilities as a Mental Deficiency Division of the government’s Mental Health Services was established. In 1964 Irabeena was taken over by the Mental Deficiency Division and it expanded. Irabeena began to provide new services to families. ‘By the 1980s, parents were learning the language of early intervention and became accustomed to advice from psychologists, speech therapists, occupational therapists and other therapists and learning to be therapists and teachers themselves’ (Charlie Fox 2010).

The Mental Deficiency Division began the process of deinstitutionalisation and integrating people with intellectual disabilities into the community within hostels. The biggest hostel was Pyrton Training Centre in Guildford Victoria that was set up in 1967 for children under 12. Pyrton was still an institution even though the people who resided there learned skills. Pyrton was shut down in the 1990s when deinstitutionalisation began.
Disability Services Revolutionise

‘In the 1970s and 1980s, the focus of disability services shifted to a training model, in which it was believed that all people with disabilities who could learn and develop skills in restricted settings should be encouraged to do so’ (The Lost Generation Project 2009).

In 1974 the United Nations produced a Declaration of Rights of Disabled Persons. These rights were not binding but provided a framework in which United Nations members could refer to when making domestic law. The 13 rights included:

1. Definition of the term "disabled person" as "any person unable to ensure by himself or herself, wholly or partly, the necessities of a normal individual and/or social life, as a result of deficiency, either congenital or not, in his or her physical or mental capabilities".

2. Assertion that these rights apply to all disabled persons "without any exception whatsoever and without distinction or discrimination on the basis of race, colour, sex, language, religion, political or other opinions, national or social origin, state of wealth, birth or any other situation applying either to the disabled person himself or herself or to his or her family".

3. Right to respect for human dignity.

4. Right to same civil and political rights as other human beings.

5. Right to measures designed to enable self-reliance.

6. Right to medical, psychological and functional treatment as necessary.

7. Right to economic and social security, including the right to employment.

8. Right to have consideration of special needs at all stages of economic and social planning.

9. Right to live with their families or with foster parents and to participate in all social, creative or recreational activities.

10. Right to protection against exploitation, discrimination, and abuse.

11. Right to qualified legal aid.
12. Right to consult organizations of disabled persons for in matters of concern.

13. Right to be fully informed of the rights proclaimed in the Declaration.

Although these rights were not binding, they signalled an important point in history, where international institutions were recognising people with disabilities as having the same rights as those without disabilities. This shift in international thinking would assist changes being made in member countries.

In 1977 the Report of the Minister’s Committee on the Rights and Protective Legislation for Intellectually Handicapped Persons (The Cocks Report) was created. This was the first report that recommended a shift away from institutional care and that future service direction needed to be based on the principles of Normalisation. ‘It found that the institutional model was inconsistent with modern cultural values and that new service models were needed. This theme has continued to underlie all subsequent government policies’ (Cameron, J. W 2000: 16).

It was during the 1980’s that for the first time the State’s education system established education support schools, centres and units to support the needs of children with intellectual disabilities within the education system.

In 1983 the government commissioned the Richmond Report. This report inquired into the health services for the psychiatrically ill and intellectually disabled. The report recommended that the mental hospitals should be shut down and the people who reside there may be supported in community housing.
Disability Services Act 1986

The Intellectual Disabled Persons’ Services Act 1986 was created to replace the Mental Health Act of 1959. This Act was revolutionary as it aimed to begin deinstitutionalisation, increase service provision and for the first time, include people with intellectual disabilities into the wider community. Some of the Act’s provisions were:

1. A statement of principles for the management, development and planning of services for people with an intellectual disability.
2. The primary themes of the 15 principles include:
   a. An equal right to a reasonable quality of life.
   b. Promoting integration of people with an intellectual disability into the community.
   c. Recognition of the capacity of people with an intellectual disability for physical, social, emotional and intellectual development.
   d. Holding service providers accountable for providing quality services and advancing the rights of people with an intellectual disability.
   e. Requirements for individual planning in respect to each person with an intellectual disability that seeks services from the department (Cameron, J. W. 2000: 16).

This report was revolutionary as it, for the first time in Australian disability policy, acknowledged that people with intellectual disabilities can develop their skills when given the appropriate opportunities. It also marked the shift in care from the medical model of care to the individualised, development model of care that currently shapes service delivery today. It was ‘the first coordinated approach to assisting people with a disability gain and maintain employment in the open labour market’ (Disability Services Australia 2013). Person centred approaches are ways of working towards achieving choices, aims and goals of people on their terms.

People were moved out of Claremont and Kew Cottages into hostels or group homes. State services were established to support families to raise their children at home. For the first time people with disabilities were supported to
access and maintain employment in the mainstream labour market (as opposed to sheltered employment).

Inspired by the UNDHR, discrimination became illegal and many parents and those with intellectual disabilities demanded their rights. The Disability Services Commission became separate government department. The disability sector became privatised which developed a consumerist market in the disability field. This allowed for private and government funded services to continue to grow and offer a multitude of services/therapies/support through a buy and sell market. Individuals were given funding to buy the services in which they wanted.
UN Convention 2006

The United Nations ‘Convention on the Rights of Persons with Disabilities’ was enacted in Australia in 2006. This convention ratified the widest range of rights for people with disabilities. Australia adopted and ratified it in 2008. This Convention recognised that people with intellectual disabilities:

- Have equal rights to live in the community as all others.
- Need to have access to a range of support services to support living and inclusion within the community.
- Are to be involved in developing and implementing legislation and policies that concern them.
- Need to have a greater deal of control over the services in which they receive.

‘Article 24 - Education

1. State Parties recognize the right of persons with disabilities to education. With a view to realizing this right without discrimination and on the basis of equal opportunity, State Parties shall ensure an inclusive education system at all levels and lifelong learning directed to:

- The full development of human potential and sense of dignity and self-worth, and the strengthening of respect for human rights, fundamental freedoms and human diversity;
- The development by persons with disabilities of their personality, talents and creativity, as well as their mental and physical abilities, to their fullest potential;
- Enabling persons with disabilities to participate effectively in a free society.

2. In realizing this right, States Parties shall ensure that:

- Persons with disabilities are not excluded from the general education system on the basis of disability, and that children with disabilities are not excluded from free and compulsory primary education, or from secondary education, on the basis of disability;
- Persons with disabilities can access an inclusive, quality and free primary education and secondary education on an equal basis with others in the communities in which they live;
c. Reasonable accommodation of the individual’s requirements is provided;
d. Persons with disabilities receive the support required, within the general education system, to facilitate their effective education;
e. Effective individualized support measures are provided in environments that maximize academic and social development, consistent with the goal of full inclusion’ (United Nations 2006).
Disability Act 2006

In Victoria the *Disability Act 2006* replaced the Disabled Persons’ Services Act of 1986 and the Disability Services Act 1991. This Act contained two sets of principles, relating to people with a disability and to service providers.

Principles for people with a disability:

- Have a capacity for physical, social, emotional and intellectual development.
- Have the **right to opportunities to develop and maintain skills** and to participate in activities that enable them to achieve valued roles in the community.
- **Services for persons with an intellectual disability should be designed and provided in a manner that ensures developmental opportunities exist to enable the realisation of their individual capacities.**
- Respect for their human dignity.
- Freedom from abuse, neglect and exploitation.
- The right to realise their potential.
- The right to have control over their lives.
- The right and support to be involved in decision making about their lives.
- Information provided in a way that suits their communication needs and their culture.
- Services that support their quality of life.

Principles for service providers should:

- Give choices.
- Be flexible.
- Respect and include family and significant others.
- Provide services appropriate to age, culture and capacity.
- Be aware of the needs of children with a disability.
- Make sure people have assistance with decision making if they need it.
- Provide high-quality services.
- Choose the least restrictive option if necessary to keep people safe.
- Advance the inclusion and participation in the community with the aim of achieving their individual aspirations.
- Maximise choice and independence of persons with a disability.
The Disability Services Act 2006 recommended **person centred planning** to be conducted when creating support plans. It states that planning should be individualised, self-directed by the person with a disability, consider the role of family and carers, support communities to respond to the persons goals and needs, be underpinned by the right of the person to have control over their own life, advance inclusion and participation within the community, maximise choice and independence facilitate tailored and flexible responses to the individual goals of the person.
Quality Framework 2007

In Victoria the Quality Framework was revised in 2007 since it was implemented in 1997. It was revised to support the State Disability Plan 2002-2012 and to incorporate the principles of the Disability Act 2006. It was designed to measure, monitor and improve services that people with disabilities use. Three new elements include outcome standards, outcome measurements and a framework for independent quality monitoring. These are used to measure service delivery, ensure people are getting a quality service, to provide evidence to see if services are making a difference in people’s lives. The Quality Framework presents an opportunity to examine the impact our service has on outcomes of people with a disability. To do this we look at 16 life areas to develop tools that collect information and evidence directly from the people we support. These life areas are identified to be important to all Victorians and any planning done with people needs to take these life areas into account.

The 16 life areas are:

1. Doing valued work
2. Always learning
3. Building relationships
4. Building part of a community
5. Having fun
6. Expressing culture
7. Being safe
8. Communicating
9. Exercising rights and responsibilities
10. Being independent
11. Looking after self
12. Choosing supports
13. How to live
14. Where to live
15. Paying for things
16. Moving around

Finding out what is important to each of the individuals who attend our services must drive our practice of service delivery. Independent monitoring occurs to verify that service providers comply with these standards all disability support workers must work within these service standards.
The Department of Human Service Standards 2011

The Department of Human Service Standards 2011 was created alongside the NDIS and represents a single set of service quality standards for service providers delivering services to clients. The standards are summarised as empowerment, access and engagement, wellbeing and participation. The purpose of these standards is to make sure that service providers acknowledge people’s rights, that they focus on measurable outcomes including client outcomes and to encourage continuous quality improvement. Most service providers will be independently reviewed from 2012 and every three years from this date.

The Department of Human Services Standards 2011 highlighted two new approaches to disability learning in which day services must uphold. These approaches are active engagement and strength based learning. In standard three ‘wellbeing’, the standard focused on ‘the role of service providers in using strengths-based approach by identifying and building on the existing capabilities of the person. It addressed the need to use active engagement and early intervention strategies’ (DHS 2011:10). It acknowledged that service providers can do this by making an assessment to identify the strengths, risks, wants and needs particular to each person that is carried out in a manner that is sensitive to age, ability, gender, sexual identity, culture, religion or spirituality, language and communication needs. The service provider needs to document and implement a goal-oriented, person centred case management plan for each person that includes strategies to achieve the identified goals.

The service provider must meet with the person to identify their strengths and aims to build on them. The service provider must then adopt active engagement and early intervention strategies. Policies and processes must reflect a strength based approach to service practice.

Standard 4 discussed participation of individuals within the day service. It focused on the role of service providers in supporting people to exercise their choice in decision making about their lives and their service delivery. It stated that service providers are to support people in identifying their own goals and pursue opportunities to be involved in their own community. Service providers are to use engagement strategies that are age, culturally and developmentally appropriate during assessment, planning and evaluation. This is to enable the understanding of each person’s views, needs and wishes. It also acknowledges the importance of people having access and support to engage in a wide range of meaningful education, recreation, leisure, cultural and community events.
that reflect their interests and preferences. **This standard is about people having access to lifelong learning education and training.** ‘People are supported to develop and maintain independence, problem solving, social and self-care skills appropriate to their age, developmental stage and circumstances’ (DHS 2011:16).

In 2011 the Productivity Commission investigated the unmet needs of people who have a disability. They recommended that a National Disability Insurance Scheme to fund appropriate levels of care and support to meet these unmet needs. ‘The Council of Australian Governments (COAG) agreed on the need for major reform of disability services in Australia through the NDIS’ (Disability Services Australia 2013). They agreed to a ten year plane called the National Disability Strategy 2011. This plan had six priority areas to improve the lives of the people with disabilities ‘including inclusive and accessible communities; rights protection, justice and legislation; economic security; personal and community support; learning and skills; and health and wellbeing.

The NDIS was introduced in Victoria in 2013. The purpose of the NDIS is State wide reform, to fund the unmet need of people with disabilities in Australia and to revolutionise the way in which they and their families are supported. This group of individuals will have more control over their service and support they wish to receive. They will have a greater flexibility as to the range of options and service providers they wish to use.
Section 2: Strategies to Support Active Engagement and Strength based Learning

The role of disability support workers has evolved over time from doing things TO people, doing things FOR people (medical model), doing things WITH people, to SUPPORTING people to do things themselves (developmental model). This shift alongside international and domestic policies outlined in section 1, have implications on the way in which staff work with people who have intellectual disabilities.

According to the DHS 2011 service providers must promote, reflect and uphold the rights of the people who attend our services. They must deliver a person centred service. They must incorporate active participation of the person in all stages of their person centred planning for support. They must uphold strength based values in all areas of individual planning to ensure that individuals build on their capabilities, independence and choice making. Service providers must support people to reach their full potential through active engagement in activities.

At Connections we support people to outline their goals, aspirations and dreams in their PCP’s, and based on this we create individual goals for each person for each activity in which they participate. We create realistic SMART goals that use the strength based model to build on people’s capabilities and strengths.

This section of the report will highlight strategies of how we can SUPPORT people to fulfil these goals and to develop their skills in a practical way during our activities using active engagement and the strength based model of support. The purpose of this section is to provide staff with an understanding of how to support people to fulfil their goals and dreams, to develop their independence and choice making skills and their individual capabilities to the best of their ability and to uphold their personal rights.

For the purpose of clarity this section will be broken down into sections:
• Section 2.1. Will discuss strength based learning further and will outline strategies that staff can used to implement strength based learning within the activities they run in a day service.
• Section 2.2. Will discuss active engagement further and will outline strategies that staff can use to support people with intellectual disabilities to engage in their activities.

2.1. Strength Based Learning (DHS 2011)

The DHS Standards support strength based learning and recommend that disability providers and consequently staff use this approach as a model of practice. ‘A strengths-based approach is a philosophy for working with individuals, families, groups, organisations and communities (O’Neil 2005)... this perspective recognises the resilience of individuals and focuses on the potentials, strengths, interests, abilities, knowledge and capacities of individuals, rather than their limits (Grant & Cadell 2009)’ (Natalie Scerra 2011: 1). Saint-Jacques (2009) outlined six principles in which this approach is based upon

1. It focuses on strengths rather than limits of each individual, group and community.
2. The community is a rich source of resources.
3. Interventions are based on client self-determination.
4. Collaboration is central with the practitioner-client relationship as primary and essential.
5. Aggressive outreach is employed as a preferred mode of intervention.
6. All people have the inherent capacity to learn, grow and change.

These principles can be used in different ways to support people to achieve skill development and to empower the people who attend our day service. The aim of strength based learning is to develop the individual’s independence and to support them to manage their own lives and activities; staff must not take over the activity and competition of tasks. Empowerment is the key principle to strength based practice. For example if it takes a person half an hour to change into their bathers, ensure they are the first person in the changing room and allow them that time to help themselves.
Staff doing things for people who attend our services may save time but also takes the empowerment, independence and choice from that person. It creates reliance on staff.

2.2. Strategies for Strength Based Learning

During the **person centred planning (PCP)** stage, speak with the individual, their families and carers to identify his or her goals, strengths, aspirations and ways in which the person would like to achieve their goals. Consider the 16 life stages outlined in the Quality Framework 2007. These goals may be long term; short term goals can be implemented in individual learning plans building on the individual’s strengths. Focus on what the person **can** do, their strengths, abilities and areas in which they would like to improve.

When writing individual learning plans, consider what the person **can** do. Outline their strengths, abilities and aspirations. Write a list of all the possible skills that can be developed within your activity as well as the overall learning plan for your group. Individualised goals should be developed based on the individual’s strengths. Remember that the key principle of strength based learning is empowerment. We are supporting the individual to be empowered over his/her life. Again it is okay if the person does not achieve their short term goals, if the person is supported to be empowered to actively engage in the programme. If a person has been engaged in an activity through building on their strengths, the activity has been extremely successful!

When individual abilities have been identified, staff can support the development of learning new skills through using a person’s strengths. For example many people with autism have very strong perception skills; staff can adapt the individual learning plans to use these skills to support active engagement.

Provide an encouraging and supportive environment for people to feel comfortable and confident to give activities a go! Do not criticise, focus on what they did right! Give encouragement for their effort, if you feel a person requires some help; speak directly to that person when you are sitting near them.
2.3. Active Engagement (DHS 2011)

‘Active engagement is critical for the academic and social outcomes for students with and without disabilities’ (Carter et. al 2008, Holifield et al 2010, Lovanne et al 2003, Klem and Connell 2004 cited in Hollingshead 2014). Put simply, if a person is not engaging in their activity, there is little chance he or she will practice their existing skills or learn anything new. For this reason staff needs to know what to do to support people to actively engage in their activities so we can support them to develop their skills, learn new things and fulfil their goals and dreams.

Most research describes active engagement as individuals working on a specific task, in a timely manner such as:

- Attending to learning tasks.
- Staying on task for a predetermined period of time.
- Self-monitoring on-task behaviours.
- Taking turns without prompts.
- Following direction.
- Physical approach-calm body, eye contact, hands down.

It must be noted that if a person is in a heightened state, active engagement will be limited if not non-existent. In these situations we must use Positive Behaviour Support to support the individual to calm down.

If a person is engaging actively in the activity he or she has chosen, there will be evidence to show this. A person may show their engagement by:

- Answering questions/asking questions.
- Responding to your direction.
- Showing happiness towards the task.
- Making choices towards the task.
- Beginning to complete the task in their own way.
- Physically completing the task.
- Verbalising how to complete the task.
• Demonstrating to others how to complete the task.

Evidence to show how a person has actively participated in an activity, especially if the participation aims to achieve the person’s goals, must be written in the evidence section of his or her learning plan.

2.4. Strategies used to Promote Active Engagement

Project based activities: during the planning stage of creating an activity, plan what the group will learn during the following six months. Creating projects or an overall activity goal is the simplest way to do this. For example a walking group: buy one note book, each week the participants write/choose pictures/draw where they have been and five animals/cars/interesting things they have seen. Creating projects enables us to think outside the box, develop new skills and allows for more opportunity for participants to engage in their activity.

Breaking down the activity into simple steps is fundamental to supporting people to learn a new skill. Verbalise the instruction appropriate using appropriate communication aids. Allow for processing time. Demonstrate what is expected of the participant/how to complete the task. Give appropriate feedback when the participant is practicing the steps involved in the activity. Once the first step is achieved to the best of his or her ability the next step can be introduced. Repetition and routine is essential to support people to learn new skills.

Staff can use alternative technology to support what you are learning today. For example if the group are learning to paint, ask a participant to look up painting videos on youtube. Find educational videos online and use them to enhance the learning experience. Touch screen tablet applications are also a fun way to reinforce learning. Reading relevant books/using
worksheets/interactive stories on computers all enhance learning and literacy skills.

Activities must appeal to **individual self-interest** to assist supporting people with active engagement. If a skill is taught using resources in which a person enjoys, they would be more interested in engaging. For example if a person loves the colour red, incorporate red objects into the activity. This can be used as a reward and/or within the activity itself.

**Put the activity into context:** when appropriate support group discussion reflecting on the wider community. For example support discussions about cultural holidays that are appropriate and support learning about these holidays. Discuss where the group could access the resources used in the activity outside of the centre e.g. ask the question where can we buy paintbrushes/where do apples grow/are there any football teams in your local area? Flash cards can be used to facilitate these discussions when appropriate. Put all skills into context so there is purpose for learning certain tasks.

**PBS:** implement person centred positive behaviour support plans during your activity. For example incorporate sensory breaks, manage the environment, and establish routines/structure to support each individual in the group when necessary.

**Visual support strategies:** most people with and without intellectual disabilities are visual learners. For this reason visual aids are a great way of aiding your verbal instruction on how to complete a task. If a person does not understand what you are saying, or finds it hard to focus on what you are saying, it makes it extremely difficult for that person to complete a task. If a person does not know what you are saying this can lead to frustration, the frustration can lead to behaviours, and if behaviours exist they may hamper a
person’s learning experience (PBS). Visual aids can include COMPICs, key sign, clocks, pictures, timetables and whiteboards.

Implement **structure** into your activity: first ensure you have a person’s attention during learning time, implement structured tasks, and use a timeframe that will be repeated throughout the semester. Incorporate breaks into the activity and reward time when an activity has been completed.

**Sensory Processing**: take sensory processing into consideration when you are planning your activities. To support people in active engagement their sensory sensitivity needs must be met. A significant number of people with autism experience sensory processing disorder (SPD), this can manifest as hypersensitivity (too much) or hypo sensitivity (too little) sensory input in any one of their sensory systems. Sensory systems include the vision, auditory, tactile, kinaesthetic, proprioceptive, oral or olfactory system. “Overwhelming sensory input may result in the student developing ways of shutting out that stimuli/input, thus leading to sensory deprivation. This means that the student may not be able to access learning” (Gundry et. Al 2007:17). For this reason managing the environment and incorporating sensory breaks or sensory rewards can be fundamental to meeting individual sensory processing needs when appropriate. Also incorporating sensory processing related tasks into the activity can assist with improving individual concentration. For example during a shopping, a person who enjoys the feeling of heavy weights can be supported in engaging in the activity through carrying the shopping or pushing the trolley. (For further information please read my report relating to sensory processing disorder).

The way in which you **communicate** to the people in your group is a valuable way of supporting active engagement. One of the most important aspects to teaching is through effective communication. If a person cannot communicate effectively, be it communicating or understanding, this can lead to frustration, frustration can lead to behaviours (i.e. disengagement, tears, withdrawal), and
such behaviours can hamper the learning experience. Within a day service the adults who participate in our activities have a variety of different communication needs and staff must be flexible in their approach to support each individual. We must be able to support each individual to communicate in the way they know how and to support the development of their existing communication skills. Examples of different communication techniques include COMPICS, Key sign, gesturing, pointing, facial expressions, body language, verbal communication and electronic communication.

The majority of people with intellectual disabilities are visual and kinaesthetic learners as opposed to auditory learners. This means many people with ID learn best when using their sight or actively doing tasks. Therefore by using strength based learning to adapt your communication techniques to work with people’s strength in this area, would create an opportunity for effective communication and consequently it may support active engagement. Some strategies to ensure effective communication within your activity include:

- Ensure you have the person’s attention before you engage in communication. This can be done by calling their name, touching their hand, eye contact, sitting at their level (whatever is appropriate for that person).
- Use clear direct sentences and ensure your tone of voice is appropriate and remember sensory processing disorder. Some people may hear your voice too loudly; others may find it difficult to hear you. Frequently pause to allow for processing time.
- Hand gestures can enhance the communication experience for some people, using key sign to assist what you are saying may support people to learn new signs.
- Visual aids such as pictures, timetables or COMPICs are a great method of communication for visual learners. If you are using COMMPICs research suggests that using thick black boarders assists supporting people to focus on the picture. If you are using pictures or posters to assist with supporting people to learn new skills, ensure they are easy to see and easy to focus on (not too busy).
- Allow processing time for what you have just said. Repeat when necessary.
- Adjust sentence size to correlate to a person’s level of comprehension. A good guide is to listen to how many words a person uses in their sentences and use the same number of words when you are communicating to him or her. For example if Johnny says things like ‘I want milo’ Johnny should process ‘lunch then milo’ easier than ‘you must eat your lunch then you can make a milo’.
- Don’t talk too much, introduce one idea at a time. Actively listen to the individuals in your group. Don’t ask too many questions always have a purpose for your questions and ask questions that a person can answer. Use open ended questions to support a person to talk and let you know what they are thinking/their opinions. Avoid leading questions ‘you agree with that don’t you?’ Ask one question at a time.
- If the person uses a communication devise ensure they have easy access it throughout their day.
- If you have not understood what a person has said, ask them to repeat it, if you still do not understand ask them to say it in another way. If they have a communication book ask them to use that to assist your understanding. If possible ask another staff member of family to assist you to understand. Ask the person to show you how they say yes or no and ask yes or no questions to figure out what they are saying. Apologise for failing to understand them and never pretend to understand if you do not.

The ‘Individual Learning Activities’ section of the Learning Plan at Connections is designed for staff to outline the strategies they use to support a person to actively engage in their activity to achieve their goals. The ‘Evidence’ section of the Learning Plan we use at connections is important for monitoring how a person is engaging in the activity. It is okay if a person does not achieve their goals, as long as they are engaging and trying to achieve their goals. Questions/answers, choice making, observations, demonstration of task understanding, physically completing the task co-actively/independently, appearance of happiness towards task at hand are all proof of engagement.
Section 3: Conclusion

The present day rights of people who have intellectual disabilities have developed significantly since 19\textsuperscript{th} century Australia. This group of people are now believed to have the capabilities to develop their skills throughout their entire lives, and are supported by carers and their family to so. Australian Law upholds individual rights to continue to develop their skills and the Department of Human Service Standards 2011 were created to ensure that service providers support people in practicing this right. The DHS Standards 2011 state that service providers must promote a strength based approach (building in individual strengths) and active engagement (learning through engaging in activities) throughout their services. Both of these approaches have implications for staff practice as outlined in section 2.

Supporting people to develop new and existing skills and to have fun doing so is one of the primary focuses of day services. Although the staff are rarely trained teachers, this report may provide staff with some tips in supporting people to learn. To summarise, strength based learning can be promotes when staff and include individuals in all stages of person centred planning, when goals are made based on individual strengths, aspirations and dreams and when activities work around individual strengths. Active engagement can be supported if staff incorporates into activities:

1. Effective Communication
2. Positive Behaviour Support
3. Project Based Activities
4. Appeal to individual self interest
5. Visual Support Strategies
6. Activity in Context
7. Break down new task/skill into simple steps
8. Alternative Technology
9. Structure and Routine
10. Sensory Processing

Remember: despite best intentions, if we do too much for anyone, be it a friend, family member, stranger, colleague or person we work with, we are only taking their independence and personal empowerment away.
References:


Department of Human Services (DHS) 2011 ‘Disability Services, Day Service Guidelines’ DHS, Melbourne.


